

**DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT****I. Identifying Information**

(a) Name of Entity <b>Life Care Centers of America, Inc.</b>	D/B/A <b>Cherry Hill Manor</b>	Provider No. <b>699 41-5053</b>	Vendor No.	Telephone No. <b>(401) 231-3102</b>
Street Address <b>2 Cherry Hill Road</b>		City, County, State <b>Johnston, Providence, RI</b>	Zip Code <b>02919</b>	

(b) (To be completed by HCFA Regional Office) Chain Affiliate No. LB1

II. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under Remarks on page 2 Identify each item number to be continued.

A Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

 Yes  No LB2

B Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

 Yes  No LB3

C Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only)

 Yes  No LB4

III. (a) List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on Page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks

Name	Address	EIN	
<b>Forrest L. Preston</b>	<b>3570 Keith Street, NW, Cleveland, Tennessee 37312</b>		<b>5</b> LB5
<b>100% Sole Shareholder</b>			

(b) Type of Entity:  Sole Proprietorship  Partnership  Corporation LB6  
 Unincorporated Associations  Other (Specify)

(c) If the disclosing entity is a corporation, list names, addresses of the Directors and EINs for corporations under Remarks  
**Please See Attached Exhibit "O".**

Check appropriate box for each of the following questions

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor partnership or members of Board of Directors ) If yes, list names addresses of individuals and provider numbers

 Yes  No LB7

Name	Address	Provider Number
	<b>Please See Attached Exhibits.</b>	

Department of Health and Human Services  
Health Care Financing AdministrationForm Approved  
OMB No. 0938-0086

IV (a) Has there been a change in ownership or control within the last year? If yes, give date _____		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No LB8
(b) Do you anticipate any change of ownership or control within the year? If yes, when? _____		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No LB9
(c) Do you anticipate filing for bankruptcy within the year? If yes, when? _____		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No LB10
V. Is this facility operated by a management company or leased in whole or part by another organization? If yes, give date of change in operations <u>Lease 08/31/2000.</u>		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No LB11
VI. Has there been a change in Administrator Director of Nursing or Medical Director within the last year?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No LB12
VII (a) Is this facility chain affiliated? (If yes list name, address of Corporation, and EIN) Name <u>Life Care Centers of America, Inc.</u> EIN # <u>62-0963862</u>		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No LB13
Address <u>3570 Keith Street, NW</u> <u>Cleveland, Tennessee 37312</u>		LB14
VII (b) If the answer to Question VII.a. is No, was the facility ever affiliated with a chain? (If YES list Name, Address of Corporation and EIN)		<u>N/A</u>
Name _____ EIN # _____		<input type="checkbox"/> Yes <input type="checkbox"/> No LB18
Address		LB19
VIII. Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No LB15		
If yes, give year of change _____ Current beds _____ LB16 Prior beds _____ LB17		
Name of Authorized Representative (Typed) <u>Cindy S. Cross</u>		Title <u>Assistant Secretary</u>
Signature <u>Life Care Centers of America, Inc.</u> By: <u>Cindy S. Cross</u>		Date <u>04/04/2002</u>
Remarks		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESForm Approved  
OMB NO. 0938-0086**DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT****I. Identifying Information**

(a) Name of Entity <b>Life Care Centers of America, Inc.</b>	D/B/A <b>Cherry Hill Manor</b>	Provider No <b>41-5053 699</b>	Vendor No. <b>N/A</b>	Telephone No. <b>(401) 231-3102</b>
Street Address <b>2 Cherry Hill Road</b>	City County State <b>Johnston, Providence, RI</b>	Zip Code <b>02919</b>		

(b) (To be completed by CMS Regional Office) Chain Affiliate No.      LB1

II Answer the following questions by checking "Yes" or "No" If any of the questions are answered "Yes," list names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued.

(a) Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons or organizations in any of the programs established by titles XVIII, XIX or XX?

 Yes  No LB2

(b) Are there any directors officers agents or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by titles XVIII, XIX, or XX?

 Yes  No LB3

(c) Are there any individuals currently employed by the institution agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's organization's or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only)

 Yes  No LB4

III. (a) List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on page 2. If more than one individual is reported and any of these persons are related to each other this must be reported under Remarks.

Name	Address	EIN
<b>Forrest L. Preston - 100% Sole Shareholder</b>	<b>3570 Keith Street, NW, Cleveland, TN 37312</b>	[REDACTED]
		[REDACTED]
		[REDACTED]

(b) Type of Entity:  Sole Proprietorship  Partnership  Corporation LB6  
 Unincorporated Associations  Other (Specify)(c) If the disclosing entity is a corporation, list names addresses of the Directors and EINs for corporations under Remarks.  
Please see Exhibit "Q"

Check appropriate box for each of the following questions:

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example: sole proprietor partnership or members of Board of Directors) If yes list names, addresses of individuals and provider numbers

 Yes  No LB7

Name	Address	Provider Number
	<b>Please see attached Exhibits</b>	

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CENTERS FOR MEDICARE & MEDICAID SERVICESForm Approved  
OMB NO. 0938-0086

IV. (a) Has there been a change in ownership or control within the last year? If yes, give date _____	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	LB8
(b) Do you anticipate any change of ownership or control within the year? If yes, when? _____	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	LB9
(c) Do you anticipate filing for bankruptcy within the year? If yes, when? _____	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	LB10
V. Is this facility operated by a management company, or leased in whole or part by another organization? If yes, give date of change in operations <u>Lease - 8/31/00</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	LB11
VI. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year? <u>Administrator - May, 2003; Director of Nursing - May, 2003</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	LB12
VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN) Name <u>Life Care Centers of America, Inc.</u> EIN # <u>62-0963862</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	LB13
Address <u>3570 Keith Street, NW Cleveland, TN 37312</u>		LB14

VII. (b) If the answer to Question VII.a. is No was the facility ever affiliated with a chain? (If yes, list Name Address of Corporation, and EIN)	N/A	
Name _____	EIN # _____	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Address		LB19

VIII. Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last 2 years? If yes, give year of change _____	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	LB15
Current beds _____ LB16    Prior beds _____ LB17		

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE

Name of Authorized Representative (Typed) <u>Cindy S. Cross</u>	Title <u>Assistant Secretary</u>
Signature <u>Life Care Centers of America, Inc.</u> By: <u>Cindy S. Cross</u>	Date <u>6/30/03</u>

Remarks

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CENTERS FOR MEDICARE & MEDICAID SERVICESForm Approved  
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## DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

## I. Identifying Information

(a) Name of Entity  Life Care Centers of America, Inc.	D/B/A  Cherry Hill Manor	Provider No. Medicare 41-5053 Medicaid 00699	Vendor No.	Telephone No. (401)231-3102
Street Address  2 Cherry Hill Road		City, County, State  Johnston, Providence, RI		Zip Code  02919

(b) (To be completed by CMS Regional Office) Chain Affiliate No.      LB1

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 Yes  No

LB2

(b) Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by titles XVIII, XIX, or XX?

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100% Sole Shareholder		

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 Yes  No

LB7

Name	Address	Provider Number
	Please see attached Exhibits	

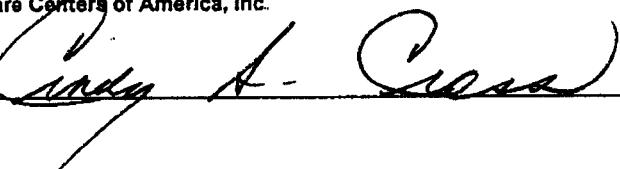
**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES**

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VI. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year? <u>Administrator 09-08-03; Director of Nursing 10-15-04</u>		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	LB12
VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN) Name _____ EIN # _____		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	LB13
Life Care Centers of America, Inc Address 3570 Keith Street NW Cleveland, TN 37312			LB14
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Address _____			LB19

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Name of Authorized Representative (Typed) <b>Cindy S. Cross</b>	Title <b>Assistant Secretary</b>
Signature <u>Life Care Centers of America, Inc.</u> By: 	Date <b>April 21, 2004</b>
Remarks	